

ACCIDENT INVESTIGATION REPORT						CASE NO.	
SECTION A – ACCIDENT INFORMATION							
1. DATE OF ACCIDENT			2. TIME (Military)	3. ACCIDENT OCCURRED <input type="checkbox"/> a. On Post <input type="checkbox"/> b. Off Post		4. EXACT LOCATION OF ACCIDENT	
a. MO	b. DAY	c. YR					
SECTION B – PERSONNEL INFORMATION							
This information is for accident prevention purposes and will be used in a manner that protects the confidentiality of employee to the extent possible.							
5. NAME (<i>Last, First, MI</i>)				6. AGE	7. SEX <input type="checkbox"/> a. Male <input type="checkbox"/> b. Female	8. STATUS <input type="checkbox"/> a. Military <input type="checkbox"/> b. Federal Civilian <input type="checkbox"/> c. Contractor <input type="checkbox"/> d. Volunteer	
9. RANK OR GRADE		10. OCCUPATION/ JOB TITLE			11. DEPARTMENT/ SERVICE/ CLINIC/ WARD/ SECTION		
12. TASK and ACTIVITY at TIME OF ACCIDENT							
13. DESCRIBE HOW the ACCIDENT OCCURRED							
14. CAUSE OF INJURY/OCCUPATIONAL ILLNESS (Check the most serious)							
a. Struck By		h. Cut by		o. Lifted Object (single action)			
b. Struck Against		i. Punctured by		p. Lifted Patient (single action)			
c. Contact with Heat		j. Rubbed, Abraded		q. Strained by (single action)			
d. Fell on Same Level		k. Inhalation		r. Stressed by (repeated action)			
e. Fell on Different Level		l. Ingestion		s. Other (Specify)			
f. Slipped, Tripped (No Fall)		m. Exposure to Body Fluids					
g. Caught In/ Under/ Between		n. Exposure to Chemicals					
15. SOURCE (Check the primary source)							
a. Doors		l. Chemical Dry/Liquid		s. Knife, Scissor, Razor Blade			
b. Ergonomics (Workstation/Patient Handling)		m. Foodservice Equipment		t. Handtool			
c. Furniture, Office Equipment		n. Body Fluids		u. Government Vehicle			
d. Ladder		o. Patient, Patient Care		v. Privately-owned Vehicle			
e. Stairs, Steps		p. Medical Equipment		w. Box, Can, Container			
f. Walking Surfaces (Floor, Street)		q. Medical Instrument		x. Glass			
g. Ventilation		r. Needle-Clean/ Dirty (Specify type, brand and gauge)		y. Trash			
h. Weather (Rain, Heat)				z. Sports			
i. Handtruck, Cart				aa. Other (Specify)			
j. Dust, Particles							
k. Steam, Vapor, Fume							
16. BODY PART(S) AFFECTED (Check primary, if greater than 1, number most serious #1, no more than 3)							
a. Body (General)		e. Nose	i. Trunk	m. Wrist	q. Knee	u. Other (Specify)	
b. Head		f. Jaw	j. Back	n. Hand	r. Ankle		
c. Face		g. Neck	k. Shoulder	o. Fingers	s. Foot		
d. Eye		h. Chest	l. Arm	p. Leg	t. Toes		
17. TYPE of INJURY/ OCCUPATIONAL ILLNESS (Check the most serious)							
a. Abrasion		h. Eye-Chemical		o. Carpal Tunnel Syndrome		v. Heat Exhaustion/Stroke	
b. Back Injury		i. Eye-Foreign Body		p. Dermatitis		w. Respiratory Condition	
c. BBP Exposure		j. Fracture		q. Disease-Infectious		x. Tendonitis/Tenosynovitis	
d. Burns-Chemical		k. Needle Sticks		r. Irritation		y. Other (Specify)	
e. Burns-Thermal		l. Puncture Wound		s. PPD Converter			
f. Contusion		m. Sprain/Strain		t. Stress			
g. Cuts/Lacerations		n. Sting/Bite		u. Hypothermia			
18. SEVERITY <input type="checkbox"/> a. Fatality <input type="checkbox"/> b. Lost Workdays <input type="checkbox"/> c. Restricted Workdays <input type="checkbox"/> d. Medical Treatment <input type="checkbox"/> e. First Aid							
19. DAYS LOST (Not counting day of injury)			20. DAYS HOSPITALIZED		21. DAYS OF RESTRICTED WORK		
22. CORRECTIVE ACTIONS. Those that have been or will be taken to prevent recurrence.							
23. Form Completed by <input type="checkbox"/> a. Supervisor <input type="checkbox"/> b. Occupational Health Clinic <input type="checkbox"/> c. Other _____		24. Name (Print/Type)		25. Signature		26. Date Prepared	